Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAN ANTONIO SPINE & REHAB
1313 SE MILITARY DR STE 107
SAN ANTONIO TX 78214

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-11-4420-02

MFDR Date Received
AUGUST 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Extent resolved per CCH decision."

Amount in Dispute: $192.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The requestor responded to the request for medical fee dispute resolution; however, a position summary was not submitted with the response.

Response Submitted by: Benita Creag, 6404 International Pkwy, Ste. 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2010	CPT Code 99213	$175.00	$95.92
August 3, 2010	CPT Code 99808-73	$15.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code Chapter 410 sets out the procedures for adjudication of extent of injury/compensability.
3. 28 Texas Administrative Code §134.203 sets out the procedures for reimbursement of services.
4. 28 Texas Administrative Code §129.5 sets out the procedures and reimbursement for the Work Status Report.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 9, 2010 and May 5, 2011

- 216 – Based on the findings of the review organization.
- 219 – Based on extent of injury.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Was the issue of compensability adjudicated prior the filing of the request for medical fee dispute resolution?
3. Were the treatment/services in dispute reimbursed in accordance with 28 Texas Administrative Code §134.302?
4. Was the DWC-73, Work Status Report reimbursed in accordance with 28 Texas Administrative Cod §129.5?
5. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(1)(A) the health care provider submitted the request for medical fee dispute resolution within the one year time frame and has met the requirements of the rule.
2. The respondent initially denied the disputed services using denial reason code "216 – Based on the findings of the review organization." Upon reconsideration the respondent did not uphold the denial reason code "216 – Based on the findings of the review organization" and denied the services using denial reason code "219 – Based on extent of injury." Review of the submitted Contest Case Hearing Decision and Order shows the extent of injury was adjudicated. The Hearing Office signed the Decision and Order on May 31, 2011. According to the Decision and Order, "The compensable injury of May 13, 2008, extends to include L2/L3 herninated nucleus pulposus (HNP) with segmental instability at L2/L3. The compensable injury of May 13, 2008 does not extend to include lumbar radiculopathy, and L3/L4, and L5/S1 herniated nucleus pulposus (HNP)."

   The first disputed issue is CPT Code 99213. This code is defined as an office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family. Review of the subsequent evaluation report states in part, "MRI of the lumbar spine reveals at L3-L4 segmental instability is seen with mild subluxation and retrolisthesis with flexion and extension. A moderate left subarticular disc excursion is noted extending into the lateral recess of L3 flattening the thecal and impinging upon the left L3 nerve root. Mild canal stenosis is present. The extrusion fragment measures 0.6 x 0.6 cm in the transaxial plane ans 2.2 cm in the superior to inferior dimension. Severe narrowing of the left with moderate narrowing of the right neuroforamen is seen….", The requestor billed diagnosis codes: 1. 722.10 – Displacement, lumbar intervertebral disc without myelopathy; 2. 847.3 – Sprain and strain of sacrum; 3. 729.1 – Unspecified myalgia and myositis; and 4. 729.2 – Unspecified neuralgia neuritis and radiculopathy. Review of the health care provider's bill shows that the number one diagnosis code is listed as 722.10; review of the requestors notes, as documented above, shows the office visit did involve the compensable injury.
3. In accordance with 28 Texas Administrative Code §134.203(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. The respondent did not reimbursement the health care provider for the service/treatment in dispute.
4. In accordance with 28 Texas Administrative Code §129.5(d) The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee. Review of the documentation submitted by the requestor does not contain a copy of the DWC-73 – Work Status Report. Therefore, the services cannot be confirmed as billed.
5. Review of the submitted documentation finds that the requestor is due reimbursement for CPT Code 99213 but not CPT Code 99080-73, DWC-73 – Work Status Report.

Conclusion

For the reasons stated above, the Division finds that the requestor has established reimbursement is due. As a result, the amount ordered is $95.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $95.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 22, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.